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Primary Health Care in Nigeria: From Conceptualization to Implementation

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ABSTRACT

Primary Health Care (PHC) is a grass-root management approach to providing health care services to communities. Since the concept was first published in 1978, various countries have attained different levels of progress in implementing the strategy. This paper reviews the historical concepts that have driven primary health care in Nigeria. Current efforts at revitalizing primary health care in Nigeria include the Midwives Service Scheme (MSS), PHC Reviews, National Health Management Information System (NHMIS), and the Maternal Newborn and Child Health (MNCH) Week. In all, the role of the people, government, and health workers as critical stakeholders needs to be well defined and pursued in order to maximize the benefits of primary health care.

Keywords: Primary Health Care, Management, Nigeria.

INTRODUCTION

Since the global target of Health for All was declared in 1978, primary health care (PHC) has been adopted and accepted universally to be the approach to achieving this lofty goal. The world will only become healthy when we achieve Health for All- the developed and developing nations alike, the poor and the rich, the literate and the uneducated, old and young and women, children and the elderly. The primary health care system is a grass-root approach meant to address the main health problems in the community, by providing preventive, curative and rehabilitative services (Gofin, 2005, Olise, 2012).

As defined in the Alma Ata declaration, primary health care is the "essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (WHO, 2012).

The principles of primary health care underscore the great value of the approach. These principles which include essential health care, community participation, equity, intersectoral collaboration, and use of appropriate technology are the driving forces behind the efficiency of primary health care as the hope of achieving universal health coverage. This means that primary health care is meant to provide services to the majority of the people based on needs without geographical, social or financial barriers through their involvement in the planning, implementation and evaluation of health programmes. It implies drawing resources from within and outside the health sector and utilizing technologies on the basis of suitability.

HISTORY AND CONCEPTUALIZATION

In Nigeria, primary healthcare was adopted in the National Health Policy of 1988 (FMOH, 2004) as the cornerstone of the Nigerian health system as part of efforts to improve equity in access and utilization of basic health services. Since then, primary health care in Nigeria has evolved through various stages of development. In 2005, primary health care facilities were found to make up over 85% of health care facilities in Nigeria (FMOH, 2010).

Historically, there were three major attempts at evolving and sustaining a community and people oriented health system in Nigeria. The first attempt occurred between 1975 and 1980. The fulcrum of this period was the introduction of the Basic Health Services Scheme (BHSS). The Basic Health Services Scheme came into being in 1975 as an integral part of Nigeria's Third National Development Plan (1975 – 79) (Dungy, 1979, Adeyomo, 2005) and was structured along "basic health units" which consisted of 20 health clinics spread across each LGA, which were backed-up by four (4) primary health care centres and supported by mobile clinics serving an approximate population of 150,000 each. The drawback of this attempt was the non-involvement of local communities who were the beneficiaries of the services. This led to the inability to sustain the Scheme at the close of the third national development plan period.

A second attempt which was led by late Professor Olukoye Ransome-Kuti occurred between 1986 and 1992 (Kuti *et al,* 1991). This period was characterized by the development of model primary health care in fifty two (52) pilot local government areas all of which were implementing all eight components of primary health care. A key result of this dispensation was the attainment of 80% immunization coverage for fully

immunized under-five children. Meticulous application of the principle of active community participation and focus on issues relating to health systems strengthening (HSS) was largely responsible for the success recorded.

The National Primary Healthcare Development Agency (NPHCDA) was established in 1992 and heralded the third attempt to make basic healthcare accessible to the grassroots. During this period, which spanned through 2001, the Ward Health System (WHS) which utilizes the electoral ward (with a representative councilor) as the basic operational unit for primary health care delivery was instituted. This was in response to the devolution of Primary Healthcare to the Local Governments by the then military government. The Ward Minimum Health Care Package (WMHCP) which outlines a set of cost effective health interventions with significant impact on morbidity and mortality was also developed. The package took into cognizance the nation's burden of disease, current trends in disease prevalence and priority diseases of national importance. The Ward Minimum Health Care Package was developed within context of the Ward Health System and aligned with the millennium development goal (MDG) targets of Nigeria. To drive this new policy over 500 hundred model health centres were established across the nation by the federal government (NPHCDA, 2012). These centres served as a fulcrum for the establishment of the Ward Health System and the community mobilization as Ward Development Committees, which is constituted of selected community representatives, were established around the model primary health care centres.

While it was logical that Primary Healthcare, which is community oriented, be established around the tier of government perceived to be closest to the people, the sudden devolution of primary health care to the local government areas may have had negative implications on sustainability of quality as that level of governance is also known to have the weakest technical capacity. Again the Federal Government's intervention by building model health centres for the local government areas, though well-conceived, was paradoxical to the newly initiated principle of devolution of healthcare. While this intervention may have been sustainable under the unitary military dictatorship, its sustainability was challenged by the advent of democracy in 1999.

ONGOING PRIMARY HEALTH CARE REVITALIZATION INITIATIVES

Although the National Primary Healthcare Development Agency (NPHCDA) had some modest achievement in its early years, it was not until the advent of democratic governance that it earnestly began to formulate, establish and implement policies that would secure its place as the steward of primary health care in Nigeria. Particularly noteworthy amongst these are reactivation of routine immunization, polio eradication initiative, midwives service scheme (MSS), primary healthcare reviews, integrated primary healthcare governance, strengthening of the National Health Management Information System (NHMIS), and the bi-annual Maternal Newborn and Child Health Weeks (MNCHW).

Reactivation of Routine Immunisation (RI) is being effected through the development of required policies and tools provision of bundled vaccines and cold chain equipment and active participation in the entire immunisation process. The fusion of the National Programme on Immunization (NPI) with National Primary Healthcare Development Agency (NPHCDA) in 2007 marked a major stride in the delivery of integrated PHC services in Nigeria. Nigeria has recently developed a National Routine Immunization Strategic Plan (2013-2015) which highlights the Reaching Every Ward with RI services (REW); Accountability Framework for RI in Nigeria (AFRIN) and Back to the Basics: Health System Strengthening, as its pivot strategies. In keeping with the determination of the nation to interrupt the transmission of the wild polio virus (WPV) by December, 2014, the NPHCDA stepped up its polio eradication drive with the establishment of the Polio Emergency Operation Centres; strengthening of the national and sub-national immunization plus days in addition to community sensitizations and various stakeholder meetings as strategies to overcome socio-cultural and other barriers to achieving this target.

The Midwives Service Scheme (MSS) is a national initiative designed to improve the quality of (and access to) maternal and child health services with the overall goal of morbidity and mortality reduction. The MSS utilizes a cluster model of hub and spoke arrangement in which four (4) selected primary health care facilities with capacity to provide Basic Essential Obstetric Care (BEOC) are clustered around a General Hospital with the capacity to provide Comprehensive Emergency Obstetric Care (CEOC) and which serves as a referral facility (NPHCDA, 2013a). The

scheme currently covers 250 clusters comprising of 1000 primary health care facilities and 250 General Hospitals in Nigeria.

Quarterly Primary Healthcare Planning and Reviews (PHC Reviews) were introduced in 2010 to monitor the progress in implementation of PHC component of the National Strategic Health Development Plan (NSHDP). The reviews currently utilize the Diagnose-Intervene-Verify-Adjust (DIVA) model. This methodology provides real-time evidence to inform policy decisions at all levels of decision making across six (6) determinants of PHC outcomes. These include availability of commodities, human resources and geographical accessibility representing the supply side determinants while on the demand side, initial utilization, continuity and quality coverage are examined during the reviews. A key constraint in sustainability of this intervention is the poor buy-in of the various state governments. Although all the thirty six (36) plus the federal capital territory have been trained on this methodology, the NPHCDA reports that as at 2013, only Lagos, Kaduna and Nasarawa states have initiated some level of institutionalization of the process.

Attempts at addressing the series of management challenges confronting primary health care in Nigeria have led to the renewed interest in the establishment of a unified state level structure that should have the responsibility of coordinating the management of primary health care systems/services (NPHCDA, 2013b). Hence the need to integrate primary healthcare governance within the concept of '**PHC Under One Roof**'.

The PHC Under One Roof Initiative aims to strengthen the primary healthcare system through the implementation of the Principle of "Three Ones"- One Plan, One Management and One Monitoring and Evaluation System- for Primary Health Care.

In response to the challenge of poor health data management, the Federal Ministry of Health (FMOH) took leadership in the harmonization of routine data collection tools in 2013. The harmonized **National Health Management Information System (NHMIS)** tools and revised HMIS policy were developed and adopted by the 56th National Council on Health in 2013. The implication is the institution of the web-based District Health Information Software (DHIS 2.0) as the national platform for all health related data

in Nigeria (FMOH, 2013). Nationwide capacity building on this system and policy is ongoing with support from development partners and non-governmental organizations. Although data reporting rates have increased since the commencement of this system, the quality of routine health data in Nigeria still leaves much to be desired, this is further compounded by the poor private sector compliance and buy-in into the NHMIS.

The bi-annual **Maternal Newborn and Child Health Weeks (MNCHW)** was launched by the Federal Ministry of Health in 2009 to provide the much needed platform for the delivery of cost-effective interventions aimed at reducing the existing high morbidity and mortality rates in children (NPHCDA, 2011; Ordinoha, 2013). During the week, primary healthcare services are offered in health facilities, from house to house, and at community stations. The services offered include immunizations, anthropometry, distribution of food supplements, distribution of mosquito nets and health education.

IMPLEMENTING PRIMARY HEALTH CARE IN NIGERIA

The great idea of grass-root health care delivery as encapsulated in the principles of primary health care requires the strong commitment of all stakeholders to make it work. Stakeholders are those persons or groups that have vested interest in the delivery of primary healthcare services and in healthcare decisions (AHRQ, 2014). The key primary health care stake holders include the people, the government, and the healthcare workers. The people need to own primary health care through adequate *community mobilization*. Community mobilization is the process of arousing the interest of the people and encouraging them to participate actively in finding solutions to their problems (Olise, 2012). When the communities are involved in the planning, implementation and evaluation of primary healthcare services, they will not perceive them as being dumped on them. Community mobilization is a veritable tool for engendering support for primary health care, especially in the rural areas where over 66% of the Nigerian population live and the worst health indices are found (NPC and ICF Macro, 2009; FMOH, 2010). Aspects of community mobilization include community entry, community dialogue, and operation of development and health committees.

Government at all levels must express, in practical terms, *political commitment* through funding, capacity building and system support. They must put money where their mouth is and translate the great ideas behind primary health

care into great programmes and great services. Primary health care services are not third-class services meant for third-class citizens. Therefore, adequate provision must be made in national, state and local budgets for quality healthcare delivery using the primary healthcare system. The role of government is critical in promoting access to essential and quality health services (FMOH, 2010). This can be channeled through the building and maintenance of infrastructure, training and retraining of the workforce, and provision of materials and equipment for effective health care.

Health care workers involved in primary healthcare delivery in Nigeria include doctors, nurses/midwives, community health workers, laboratory scientists/technicians, and health assistants among others (Africa Health Workforce Observatory AHWO, 2008). To make primary health care work, workers need to contribute their quota to improving quality service delivery and achieving clients' satisfaction. This they can do through *innovative utilization* of available resources, encouraging patient participation in their care, and promoting healthcare worker-patient communication (Babatunde *et al,* 2013). The disposition of healthcare workers is very important in enhancing public perception and utilization of primary health care services. Commitment to duty, empathy, and a listening ear are desirable traits in primary health care workers that can enhance service delivery.

CONCLUSION

The concept of primary health care is still relevant to achieving equitable and quality health care for all Nigerians. However, a persistent effort at implementation at all levels is necessary to maximize the benefits of this people-oriented approach to health care.

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